

Please take the time to fill this out with as much detail as you are comfortable with. The questions are close together on the form, but you can create as much space as you need to answer each question.

CLIENT INTAKE INFORMATION HEALING TOUCH/ HERBAL/ MANUAL THERAPY

NAME:

ADDRESS:

PHONE:

AGE/DOB EMAIL:

DATE:

WHO REFERRED YOU?

REASON FOR APPT:

WHAT IS IT YOU HOPE TO ACHIEVE FROM THIS APPOINTMENT?

ANY KNOWN IMBALANCES:

CURRENT LIVING SITUATION:

CURRENT WORK SITUATION:

HEALTH CARE PROFESSIONALS YOU ARE WORKING WITH:

CURRENT MEDICATIONS,SUPPLIMENTS,
PAST SURGERIES

PAST INJURIES OR SIGNIFICANT HEALTH PATTERNS PERTINENT FAMILY MEDICAL
HISTORY

DO YOU SMOKE?

WHAT DO YOU DO FOR EXERCISE?

HOW DO YOU GENERALLY FEEL EMOTIONALLY?

ARE YOU BOTHERED BY WEATHER CHANGES?

DESCRIBE YOUR SLEEP PATTERN

DO YOU LIKE YOUR BODY?

WHAT DO YOU DO FOR HOBBIES/RECREATION? WHAT GIVES YOU JOY?

WHAT ARE YOUR SPIRITUAL BELIEFS/PRACTICES?

DESCRIBE YOUR DIGESTION

TYPICAL DAY OF MEALS/FLUIDS:

**Before your appointment, please track 3 consecutive days of food and fluid intake-
IMPORTANT- Please be specific and do not change your habits, we need a clear baseline to start
from- no judgements, just write it down (Use the back of this form)**

IS THERE ANYTHING ELSE YOU THINK ITS IMPORTANT FOR ME TO KNOW RIGHT NOW?